



CLAIM -- VOUCHER

State Form 11294 (R 4/1-96)

Approved by State Board of Accounts, 1996.

Name of agency personnel who prepared this claim.

Name:

Phone:

INSTRUCTIONS: This agency is requesting disclosure of your Social Security Number in accordance with I.C. 4-1-8

VENDOR INFORMATION						AGENCY INFORMATION			
Document Number			Date (Month, Day, Year)			Agency Name			
Vendor Name						Agency Number			
Address (Number, Street)						Social Security Number		1099 CODE	
Address (P. O Box Number)						Federal I. D. Number		1099 CODE	
City, State, and ZIP Code (00000-0000)						Vendor Number			
AREA BELOW TO BE COMPLETED BY AGENCY.									
DATE	AMOUNT	FUND	OBJECT	CENTER	LOAN/INV/NBR	QTY.	UNIT	DESCRIPTION	
GROSS AMOUNT \$						Furnished to: (Name of State Agency)			
I certify that this claim is correct and valid and is a proper charge against the State Agency, Fund, and Center indicated.									
Authorized Signature of State Agency						Date (Month, Day, Year)			
Pursuant to the provisions and penalties of Indiana Code 5-1-11-10-1, I hereby certify that the foregoing Fund and Center is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.									
Signature of Vendor						Date (Month, Day, Year)			